CHILD AND ADOLESCENT PSYCHIATRIC SOCIETY OF GREATER WASHINGTON

CAPSGW

Fall/Winter 2012

Inside this issue:

President's Message

Brent Anderson, M.D.

CAPSGW, through a grant from the Campaign for America's Kids, supported the Early Career Psychiatrists Connect program this year. The funds allowed CAPSGW to reach out to ECPs in new and novel ways. CAPSGW hosted two events this year.

The first ECP event was held at the home of Susan Rich, our Maryland Representative, on March 11, 2012. Her home provided a comfortable environment for the gathering of ECPs. The beautiful spring day and the stunning natural setting added to the ambiance of the event. Clifford Sussman, our CAPSGW Multimedia Development chair, helped attendees with the sign-in process. Dr. Rich served refreshments and attendees had time to meet one another. Brent Anderson welcomed attendees and spoke about opportunities to become involved in AACAP and CAPSGW. Dr. Rich discussed her experience having a private practice with a home office. She also spoke about working with allied mental health professionals. Afterwards, attendees were given the opportunity to network.

The second ECP event was held at Sequoia Restaurant in Washington, D.C. on June 21, 2012. Sequoia provided a beautiful setting overlooking the Potomac River and is a popular place for young adults. Jeanne Holzgrefe and Rebecca Edelson organized the event. It started with a reception where ECPs could interact with each other and CAPSGW executive committee members. This was the first CAPSGW event for some ECPs. They were interested in meeting others and sharing various career experiences.

Brent Anderson welcomed the ECPs and introduced Alan Ezagui from AACAP. He invited those attending to become involved in CAPSGW and encouraged them to think about running for positions in the upcoming fall elections. Jeanne Holzgrefe provided an update on Maintenance of Certification. This is an important topic, as ECPs will have to recertify every ten years. She discussed the various parts to certification and current issues that have been debated within AACAP and APA. The ECPs were very attentive during the presentation and actively engaged in discussion about this topic afterwards.

ECPs were appreciative of having this event and will want to have future events. The ECPs hope that the Campaign for America's Kids will continue to support the ECP Connect Program. CAPSGW acknowledges Angelica Kloos for submitting the grant application and Rebecca Edelson for completing the grant process. ■

Welcome to New CAPSGW Members!

Peter Mikhail, M.D., First Year Child and Adolescent Psychiatry Resident at Georgetown University Hospital

Naimah Weinberg, M.D., National Institute on Drug Abuse/ NIH

Joseph Dougherty M.D., Child and Adolescent Psychiatry Service at Walter Reed National Military Medical Center

Results of CAPSGW Survey on the new Maintenance of Certification (MOC) Requirements and Related Quality Assurance Issues

Jeanne Holzgrefe, M.D. Ph.D.

You may have responded to a recent CAPSGW survey seeking feedback from our members. Thank you so much! The following summarizes the data that were collected from the survey.

The purpose of the CAPSGW Survey was to obtain members' feedback on the new MOC requirements, in particular, the Clinical Modules and Patient and Peer Feedback Modules. Currently, these modules are scheduled to take effect in 2013. The Survey also solicited members' opinions on the more general role of professional organizations in quality assurance efforts.

The Survey was developed by CAPSGW and distributed to members via the CAPSGW email list serve and Survey Monkey. Notice of the survey was initially emailed to the CAPSGW membership in mid-October and the survey remained open until mid-November. The response rate was 25%, which is reported to be in-line with previous CAPSGW surveys. Eighty-three percent of respondents are Board Certified in Child and Adolescent Psychiatry. Sixty percent were certified on or after October 1, 1994, and are therefore subject to the new MOC requirements.

Eliminating the patient feedback requirement of MOC was endorsed by 86% of respondents of the recent CAPSGW Survey on new MOC Requirements and Related Quality Assurance Issues. A large majority of respondents (73%) believe that before the new Performance in Practice (PIP) Requirements, including both Clinical Modules and Patient and Peer Feedback Modules, are implemented, the evidence-based need for them should be scientifically demonstrated in a variety of practice settings. As one survey participant commented, "I believe in evidence-based medicine, and even more in evidence-based regulations."

Results of the Survey (as per the summary below) have been sent to Michael Houston, M.D., Chair of a Task Force on MOC who will forward the results to Marty Drell, M.D., President of AACAP. Results of the Survey and a copy of the Survey will be sent to AACAP Delegates to the Assembly of Regional Organizations. Hopefully, member feedback from across the country will help AACAP address these issues in a way that reflects members' opinions. This information will also be sent to the APA Caucus on MOC issues. Within CAPSGW, we will be sponsoring discussions on the role of CAPSGW in addressing these quality assurance and related issues.

Pilot Testing of Clinical Modules. A large majority of respondents believe that pilot testing is needed before implementation of Clinical Modules. Specific goals of pilot testing include determining the effectiveness of Clinical Modules in improving quality of care (81% agreed or strongly agreed), the amount of physician time needed and costs to implement Clinical Modules (83% agreed or strongly agreed) and the cost-effectiveness of Clinical Modules (80% agreed or strongly agreed). One respondent noted, "I think the bar has become onerous. While I feel continuing CME and MOC exams are helpful, everything else just seems like a lot of extra time and effort for no real proof it makes us better doctors." Another survey participant commented, "I feel that these modules are trying to emulate what hospitals do for recredentialing…." Another person stated, "I feel the requirements penalize people in private practice…."

Possible alternative to chart review. Seventy-six percent agreed or strongly agreed that completing a clinical module in which current practice guidelines are applied to a hypothetical patient could be an alternative to chart review, 13% were neutral, and 11% disagreed or strongly disagreed. One respondent noted, "This might be a better alternative due to privacy violations that can occur from sharing patient information with too many individuals/evaluators."

Patient Feedback Requirement. As previously noted, 86% of respondents believe the patient feedback requirement of MOC should be eliminated. The Survey asked about some of the concerns raised in obtaining Patient Feedback for the purpose of MOC, including creating boundary issues (95% agreed or strongly agreed), creating ethical conflicts (89% agreed or strongly agreed) and having the potential to damage treatment (86% agreed or strongly agreed). One respondent cautioned, "A practitioner might practice in a particular fashion that might not necessarily be therapeutic in order to obtain a more favorable patient feedback." Another stated, "Looking at the business aspects of the practice of medicine, it can be useful to survey consumers as to their satisfaction. However, I don't feel it is a necessary or meaningful part of board certification." Another person wrote, "I don't pay dues for patient advocacy…this is my trade organization and I would like to see it fight all these nonsensical things that come up. Patients have their advocacy groups. AACAP should never worry about looking biased."

(Continued on page 3)

Survey Results cont.

(Continued from page 2)

Peer Feedback Requirement of MOC. Fifty-eight percent of respondents believed Peer Feedback should be eliminated from MOC, 22 % had no opinion, and 20% felt it should be included. One respondent noted that there is a "question of reliability/ potential conflicts of interest in peer feedback."

Role of Professional Organizations in Quality Assurance. Ninety-one percent agreed or strongly agreed that one role of professional organizations should be to advocate for scientific review of data obtained from a variety of practice settings on the evidence-based need for and cost-effectiveness of such proposed quality control measures, before such proposed recommendations are implemented. Nine percent were neutral, and no one disagreed or strongly disagreed. One respondent commented that professional organizations should "exercise some oversight on regulations on our profession using …evidence-based principles. Unfortunately, our professional organizations are not doing this. This could be one reason membership in many professional organizations is decreasing."

Eighty-nine percent of respondents agreed or strongly agreed that one role of professional organizations should be to provide education and public information directed toward the media, elected officials, insurance companies and the public regarding the array of services psychiatrists offer and the mechanisms in place to ensure quality. Seven percent were neutral and four percent disagreed or strongly disagreed. One survey participant commented, "Our professional organizations should provide information that gives a more balanced view of who psychiatrists are and what we do….There is often no counterweight to…negative perceptions of psychiatrists…."

Ninety-six percent agreed or strongly agreed that one role of professional organizations should be to help identify if there are areas where the ability of psychiatrists to provide high quality care is limited by certain insurance reimbursement policies that do not allow for an adequate amount of time and/or number of sessions for effective medication management and/or psychotherapy, four percent were neutral and no one disagreed or strongly disagreed. One respondent noted, "Yes, insurance has had a corrosive effect on our practice, on our relationships with patients and we need to continue to articulate this." Another stated, "A data base on the ways in which insurance reimbursement policies limit provision of care …could be crucial." Another wrote, "Yes, AACAP should be fighting for us!!!" ■

Member Updates

Congratulations to **Rachel Ritvo**, who accepted the Catcher In the Rye Award on behalf of The Psychotherapy Committee at the 2012 AACAP Assembly Meeting.

Lisa Cullins was featured in the AACAP CAPtivated video. Watch it here: http://www.becaptivated.org/.

The Rieger Psychotherapy Prize was given to Ann Alaoglu, M.D. and the Chestnut Lodge Study Group at the AACAP meeting in San Francisco for a paper titled "Untangling Psyche and Soma: a Traumatized Adolescent with Lyme Disease" Included in this group are **Dr. Alaoglu, Dr. Richard Imirowicz**, and **Dr. E. James Anthony**.

Congratulations to **Edgardo Menvielle**, Associate Professor at Children's National Medical Center, for winning the CNMC Child and Adolescent Psychiatry 2012 Teaching Award.

Edgardo Menvielle was one of the authors of an article published in August 2012 in *The American Journal of Psychiatry* entitled "Treatment of Gender Identity Disorder." Read the article here: http://ajp.psychiatryonline.org/data/Journals/AJP/24709/appi.ajp.2012.169.8.875.pdf. He also recently published an article in the *Journal of Homosexuality* entitled "A Comprehensive Program for Children with gender Variant Behaviors and Gender Identity Disorder." In addition, he was one of the co-authors of the recently released "Practice Parameter on Gay, Lesbian, Bisexual, Transgender Youth," issued by AACAP in 2012.

The University of Chicago Magazine recently interviewed **Fred Solomon** about his personal experience with precocity. (This was on the occasion of his record as "the youngest medical school graduate" at the Pritzker School of Medicine being broken in June 2012). Read the article here: http://mag.uchicago.edu/science-medicine. Fred and his wife recently moved to Bucks County, Pennsylvania where he is getting used to retirement.

Shifting Diagnostic Paradigms for Improved Treatment and Surveillance of Fetal Alcohol Spectrum Disorder in DSM-V

Susan D. Rich, M.D., MPH

Nearly 20 years ago, inspired by the book, "The Broken Cord" by Michael Dorris, I left a job in pharmaceutical clinical trials research to complete a Master of Public Health in health policy, then attended medical school and, eventually, pursued psychiatry and child psychiatry fellowship training. An ongoing passion for prevention and treatment of Fetal Alcohol Spectrum Disorder (FASD) has led me to advocate nationally and internationally and develop grass roots programs on this topic – in small towns and villages in the Navajo Region of the Indian Health Service, as far away as Quebec and the Northwest Territories of Canada, and in major cities like San Francisco, Honolulu, Albuquerque, St. Louis, and Toronto. It was an honor and privilege to speak at our CAPSGW November dinner meeting with Dr. Howard Moss, Associate Director of Clinical and Translational Research of the National Institute on Alcohol Abuse & Alcoholism (NIAAA). Together, we shared historical, scientific, and psychiatric perspectives about the under diagnosed epidemic of neurodevelopmental disability caused by alcohol.

Years ago, as a medical student at UNC, I attended an NIAAA conference in Washington, DC which included a talk by Dr. Michael First about inclusion of FAS/FASD in the DSM. Several years later, as a resident at Georgetown, I had the privilege of meeting Howard Moss, MD, PhD at a conference sponsored by the National Organization on Fetal Alcohol Syndrome (NOFAS) in Washington, DC. He had attended my presentation advocating for Alcohol-related Neurodevelopmental Disorder (ARND) to be included in the DSM. Around that time, while serving as a NOFAS board member and Member in Training Trustee on the APA Board of Trustees, I had submitted an action paper with Dr. Roger Peele to the APA assembly to consider inclusion of FASD/ARND in the DSM. My talk emphasized the neurologic (seizure disorders & brain damage) and medical (cardiac defects, conduction anomalies, hepatic problems) that present contraindications to certain medications we use in psychiatry – encouraging the field to embrace a paradigm shift toward understanding the psychiatric and neurodevelopmental sequellae associated with prenatal alcohol exposure. Dr. Moss, who is double boarded in psychiatry and addiction psychiatry, eventually wrote a white paper recommending inclusion of FASD/ARND in DSM-V while on the workgroup for substance use disorders.

Being an early career psychiatrist, I strongly believe in seeking out like-minded mentors who can help develop our strengths and interests. In that spirit, I have come to know Dr. Moss as a brilliant scientist and mentor in the field of alcohol research. We both agree that FASD/ARND should be diagnosed by psychiatrists who currently treat the condition masquerading by mimicry of other clinical issues – ADHD, bipolar disorder, intermittent explosive disorder, and nearly every developmental disorder of childhood. I was delighted earlier this year when the CAPSGW President, Dr. Brent Anderson, suggested that Dr. Moss and I speak about FASD at a CME meeting.

History & Epidemiology: The first part of the talk, Dr. Moss eloquently highlighted societal knowledge about the harmful effects of alcohol on pregnancy, reviewing three centuries of literature pre- and post-prohibition and highlighting current worldwide epidemiological data. Given that these effects occur early in pregnancy and that some doctors still condone use of alcohol in pregnancy (or at least say, "a little is okay, just don't overdo it"), it is no wonder that rates of full FAS range between 1-3 per 1,000 live births in the US and as high as 6-10% in some communities of South Africa, while rates of partial FAS and ARND can be 2-3 times higher.

Alcohol – our society's social drug of choice – is the most potent neurodevelopmental teratogen (cause of functional birth defects) in the western world. The diagnosis of Fetal Alcohol Syndrome (FAS), the only ICD-9 diagnosable disorder in the spectrum, is largely based on facial features, and yet only roughly 20-30% of affected individuals actually have the 'characteristic facies." This is because the timing of alcohol exposure causing the facial dysmorphology must occur within the early period of organogenesis, which may not occur in women who are drinking episodically throughout pregnancy or abstain during the first trimester. There is evidence that highly educated women abstain during that period due to the misconception that it is safe to begin drinking after the first trimester.

Alcohol-related Neurodevelopmental Disorder (ARND): The second part of the talk focused on the science of alcohol teratology, associated neurodevelopmental sequellae, and the need for psychiatrists to consider FASD in a neurodevelopmental formulation of their patients. EVERY individual affected in the least bit with maternal alcohol use exhibits ARND, even if they do not meet rigorous guidelines for the facial dysmorphology. The face simply denotes early, binge (4-5 drinks) exposure during organogenesis. If the mother drinks in episodic binge amounts intermittently throughout pregnancy, her child may have significant learning issues, sensory and perceptual issues, cognitive deficits, executive functioning issues, mood dysregulation & autonomic arousal, social & language deficits, or other "functional birth defects" without the facial features.

Neurodevelopmental Teratology: Dr. Kathleen Sulik, a mentor at the University of North Carolina at Chapel Hill, showed that the major malformations associated with alcohol occur as early as weeks 3-4 post conception when the neural tube is "zipping up." At that point in early development, areas of the neural crest that will ultimately form the midline brain and facial structures are exquisitely sensitive to the effects of prenatal alcohol exposure. She dosed pregnant mice the equivalent of 4-5 servings of

(Continued on page 7)

Training Program Updates

Children's National Medical Center

It's hard to believe we're almost halfway through the academic year! But it's happening again: the first-year fellows have become very proficient on their inpatient rotations, and the second years continue to explore a broad range of CAP electives in the community, many with the facilitation or supervision of CAPSGW members (thank you!).

We've been very excited to add Martine Solages, M.D., and Cathy Southammakosane, M.D., to our faculty this fall and both have been great additions to our education and clinical team. We're also so fortunate to have many dedicated community faculty who provide excellent didactic instruction and clinical supervision to the fellows.

We enjoyed hearing from Lee Ascherman, M.D., M.P.H., from the University of Alabama at Birmingham, during our annual Saltz Grand Rounds event in October. Through his lecture, a luncheon, and a case seminar with the fellows, he provided great insights about how to be attuned to psychodynamic issues in our work with children.

Several of our fellows and faculty attended the AACAP Annual Meeting in October, including second year fellow Kory Stotesbery, D.O., who received an AACAP Educational Outreach Program travel award. The AACAP meeting is also a great place to catch up with alumni and we are excited about what our graduates are doing in the "real world!"

And of course we are already busy preparing for end-of-the year transitions. We're finishing up with interviews for the incoming class that starts July 2013 and eagerly await Match Day in January. Our second years are beginning their job searches, while the first years begin to plan their second-year clinical electives – and all continue to appreciate the warm welcome of the CAPSGW community as they develop their professional identity.

—Submitted by Sandra Rackley, M.D.

National Capital Consortium, Walter Reed National Military Medical Center

We are very pleased to welcome USAF Capt Natosha Smith, M.D., Ph.D. from LSU (under Dr. Drell!) and MAJ Greg Postal, M.D. as our first year Fellows. CPT Sylvia Johnson, M.D. has now completed required officer training and completed her first year of Fellowship on October 31. She and COL Rosangela Parsons remain the two 2nd year Fellows. The military joint services graduate medical education selection board (JSGMESB) is conducted each year during the week after Thanksgiving. We look forward to the selection of next year's class, again hoping for multi-service representation.

We continue to adjust to this new location, command structure and, most recently, fiscal constraints. Due to budgeting guidelines we were unable to attend the AACAP meeting in full force as we try to do each year. Two ticketed workshops had to be cancelled (Ms. Barbara Leiner's on the IEP and the School-based Mental Health by Maisley Paxton, Ph.D., LTC (P) Brett Schneider, M.D. and Ryo Sook Chun, M.D.). We will continue to support faculty-fellow collaboration and look forward to next year's meeting.

This will be my last year as Fellowship Director. I have been very fortunate to have held this position for 13 years! The Consortium, our Institution, conducts the search. Our Training Committee appointed MAJ(P) Joe Dougherty ('07 graduate, back after 5 years in Germany from where he deployed to Iraq) as Associate Program Director (APD). He will work alongside Anne Cannard, M.D., APD Emeritus, to assist with the electronic administrative work load.

Dr. Cannard will continue to assist with personnel and morale/welfare/faculty development. We are fortunate to have the support of the Child and Adolescent Psychiatry Service (CAPS) Chief, LTC Chris Lange, M.D,. ('02 graduate) an active CAPSGW and AACAP member who is militarily accomplished and also forensically trained and boarded. And, CAPSGW President-elect, Micah Sickel, M.D., Ph.D. is a member of the CAPS staff and part of the fellowship extended faculty.

—Submitted by Colonel Nancy B. Black, M.D.

Georgetown University Hospital

The Georgetown University Hospital/ Adventist Behavioral Health Residency Training Program in Child and Adolescent Psychiatry entered its third year in July 2012. Despite its recent inception, the program has thrived, attracting very strong physicians for its four training positions. Hassan Bokhari, M.D., and Katherine Mallory, M.D., are current second year residents and Thad Garland, M.D., and Peter Mikhail, M.D. are current first year residents. The program's first graduates, Maria McGee, M.D., and Malena Banks, M.D., have gone on to terrific positions after graduation (Dr. McGee with Montefiore Medical Center/ Albert Einstein School of Medicine, and Dr. Banks with the D.C. Department of Mental Health).

While core rotations continue to reside at Georgetown (for outpatient and consultation/liaison child and adolescent psychiatry) and at Adventist (for inpatient child and adolescent psychiatry), the program has established rotations with several important institutions in our community, including an outpatient rotation at the Jewish Social Services Agency and school rotations at The Ivymount School and Katherine Thomas School, all in Rockville, Maryland.

The Section of Child and Adolescent Psychiatry at Georgetown continues to grow, as well, with the recent addition of a new faculty member, Rongrong Tao, M.D., Ph.D., a nationally recognized expert in adolescent mood and anxiety disorders who was formerly at the University of Texas-Southwestern Medical Center. The Section has also added a monthly grand rounds program dedicated to topics in Child and Adolescent Psychiatry.

—Submitted by Matthew Biel, M.D.

Assembly Report: San Francisco, CA, October 23, 2012

Adair Parr, M.D., J.D.

Louis Kraus, Assembly Chair, opened up the 2012 Assembly Meeting. This Assembly represents the second largest Assembly ever, with 106 Assembly representatives at the meeting. In addition, two psychiatrists from Mexico were present at the Assembly. Marty Drell, AACAP President, discussed his Back to Project Future Presidential Initiative. He welcomed the new AACAP Executive Director, Heidi Fordi, who has been in her new position for seven weeks. **Paramjit Joshi**, AACAP President-Elect, addressed the assembly and introduced her presidential initiative, which is a focus on international psychiatry and collaboration with psychiatrists from other countries. Steven Cuffe then presented the Treasurer's Report. The Academy is in good shape financially, with numbers of members increasing despite the weak economy. Funding from pharmaceutical companies comprises 6.5% of the overall AACAP budget.

The new AACAP Executive Director, Heidi Fordi, reviewed some facts and figures of this year's meeting. Engaging young psychiatrists and medical students has been a recent focus of AACAP. Over 300 monitors (residents and fellows) are helping with this year's Annual Meeting. Over 200 medical students and residents are participating in the mentorship program. The Mentorship Network connects medical students and residents with child and adolescent psychiatrist mentors. Facts for Families on Obesity is a popular page on the website. *JAACAP*'s 2011 impact factor rose to 6.444 over 5.148 in 2010, making *JAACAP* the #1 journal in the category of pediatrics (out of 113 journals).

Back to Project Future, AACAP President Marty Drell's Presidential Initiative, was presented by James MacIntyre. Information about Back To Project Future is available on the AACAP website at http://www.aacap.org/cs/back_to_project_future. The project is designed to develop a blueprint for the years 2013 to 2023 for the field of child psychiatry. Back to Project Future has three subgroups: 1) Service and Clinical Practice; 2) Research; and 3) Training and Workforce.

Warren Ng discussed *AACAP News*, which has a new editor. He discussed the PAC Task Force. A webinar took place in early September discussing pros and cons of the PAC.

David Fassler and Louis Kraus discussed updates with the AMA. Issues surrounding health care reform will be reviewed at a meeting next month. One important issue to be addressed will be liability involving telepsychiatry. Louis Kraus is a member of the Science and Public Health committee of the AMA, which will be publishing a paper on antipsychotic use in children.

Sherry Barron-Seabrook gave an update on CPT coding. New coding will be in place in 2013 based on E/M coding. 90801 is no longer valid. 90791 is the new code for a diagnostic evaluation by a non-physician and 90792 is a diagnostic evaluation with medical services, which should be used by child psychiatrists. 90862 is deleted and E/M codes will be used. Psychotherapy codes have been deleted and new codes will be used. This information is available on the AACAP website at: http://www.aacap.org/cs/business_of_practice/reimbursement_for_practitioners

Complete information on the various codes is available here: http://www.aacap.org/galleries/default-file/2013_CPT_Module.pdf

Susan Milam Miller presented the ECP Connect program. The object was to connect ECPs with their ROCAPs and to encourage mentorship of ECPs and to avoid isolation in the early practice years. Fifteen grants of up to $2,000 were awarded, including one to CAPSGW.

In the Open Forum, a heated discussion of third party funding for events at professional meetings was discussed. Edmund Levin presented a resolution by the Northern California Regional Organization of Child and Adolescent Psychiatry which they have endorsed which asks that AACAP revise its Code of Ethics Principle VI: Third-Party Influence [Fidelity] to declare that the acceptance of any item whether it be gifts, dinners, educational opportunities, recreational outings, medication samples, financial support, remuneration, or monetary investments from the pharmaceutical industry to be a Conflict of Interest and that this Code of Ethics apply equally to members and to the organization itself. An AACAP Task Force on Pharma Support has been studying this issue. Paramjit Joshi, one of the task force members, followed this up with a presentation regarding conflicts of interest for pharmaceutical, which is an important issue to AACAP. In August 2012, Wayne Batzer, former Assembly Secretary-Treasurer, resigned as a member of AACAP due to continued pharmaceutical industry funding. Dr. Joshi reported that AACAP has a continuing dialogue with pharmaceutical companies involving financial support. In 2011, 5.8 percent of operating expenses were supported by pharma. Some of the support includes the following: In 2012 (through August), four percent of operating expenses were supported by pharma. $75,000 has been given by Lilly to support the international psychiatry reception this year. Eli Lilly and Shire gave support to AACAP's annual meeting in the amount of $50,000. Eli Lilly has funded research in the amount of $50,000 and Shire and Pfizer have given

(Continued on page 9)

FASD Cont.

(Continued from page 4)

alcohol (i.e., 4-5 beers, servings of wine, or shots of liquor) in the human equivalent late third to early fourth week of pregnancy. These appropriately timed early exposures produced the major malformations associated with FAS (e.g., heart defects, brain anomalies, dysmorphic facies, etc.). This means that an unintentional but precisely timed exposure of one "Long Island Ice Tea" (which contains several shots of liquor) before a woman may know she is pregnant can cause lifelong consequences to her child, including brain damage. This is, unfortunately for our society, a vulnerable time for offspring of moderate to heavy alcohol consumers – a time in which they should be counseled to use reliable contraception (as is the case with Retinoic Acid derivatives, lithium, Depakote, and other teratogenic agents we cautiously prescribe in sexually active childbearing age women).

Dr. Sulik's seminal research on the effects of early prenatal alcohol exposure went into the original US Surgeon General's Warning on alcohol and the revised warning in 2005 that women of childbearing age should use contraception when using alcohol and should take preconceptional precautions to avoid inadvertent prenatal alcohol exposure. Doctors should screen patients about their frequency and amount of alcohol use and encourage sexually active childbearing age alcohol consumers to use contraception and to plan their pregnancies after stopping alcohol use.

Medical Sequellae: Early prenatal alcohol exposure can lead to cardiac defects (VSDs, ASDs, conduction anomalies, etc.), hepatic insufficiency, gastrointestinal problems, renal issues, and seizure disorders. Plastic surgeons treat cleft lip or palate and hypospadias, neurologists treat seizure disorders and other neurologic sequellae of alcohol's damaging effects on the brain, physiatrists treat cerebral palsy and spina bifda, ophthalmologists treat strabismus, and ENTs treat chronic ear infections – all of which can be alcohol-related birth defects. These structural malformations occur at moderate to high maternal blood alcohol concentrations very early (i.e., during "organogenesis").

Inadequate Formulation: Although pediatric dysmorphologists diagnose FAS, psychiatrists and other mental health professionals treat patients with ARND. Herein lies the dilemma: the psychiatrist – not the pediatrician, pediatric dysmorphologist, or geneticist - treats the majority of lifelong problems associated with FASD/ARND as half-formulated diagnoses (i.e., garden-variety ADHD, bipolar disorder, developmental disorders of childhood). We are "blinded" to the proper diagnosis (i.e., ARND) in our formulation and treatment plan and have no clinical trials to support use of medications in this population. We treat children, adolescents, and adults with ARND in our clinics, offices, community-based programs, residential treatment, therapeutic boarding schools, juvenile training schools and detention centers every day of the week without recognizing the alcohol-induced brain injury and other underlying "silent" but potentially lethal anomalies when combined with certain psychopharmaceuticals. This incomplete perspective of a patient has the potential to lead to devastating or deadly outcomes for patients.

ARND in DSM-V? The pending publication of DSM-V is proposed to include a diagnostic category "alcohol-related neurobehavioral disorder" in section 3 for disorders "requiring further study." It would seem more appropriate to include the term "neurodevelopmental" rather than neurobehavioral (in keeping with international guidelines for developmental disorders that places ARND among environmentally-induced neurodevelopmental disorders). We in the FASD/ARND community remain hopeful that the committee of scholars will trust the forty years of research on the topic of FASD and include ARND outright rather than as a topic requiring additional study.

The topic of FASD/ARND has had more published articles than almost any psychiatric disorder in the DSM-IV TR. In fact, our knowledge of the brain-based etiology of the neurodevelopmental deficits associated with FASD/ARND rivals that of what we have learned about the brain from stroke victims and end-stage alcoholism. If only disorders requiring no further study were included, then there would be few disorders included in DSM-V. Authors of nearly every article in the Green or Orange journal, as well as JAMA and other peer-reviewed scholarly prestigious journals, note at the end: further study in this area is warranted; albeit, setting themselves up for their next granting cycle. It would seem that every disorder in DSM continues to need further research with every study published.

We psychiatrists should trust our ability to diagnose and care for individuals with ARND by including it in DSM-V. Perhaps then we will be able to design clinical trials for improved treatments, minimizing the paradoxical responses and drug side effects that so often lead to polypharmaceutical use in this fragile, brain-injured population. Thank you, Dr. Moss, for taking time to shed light on this diagnostic dilemma – improving psychiatrists' ego-strength to diagnose and treat ARND as the brain-based environmentally-induced neurodevelopmental disability that it is – and not a mimic of other psychiatric disorders. ■

For more information on this topic, see the 2009 and 2011 AACAP annual conference manuals online (Dr. Rich chaired and presented a symposium and clinical perspectives on FASD at the respective conferences). Additional information can be found at www.nofas.org and on Dr. Rich's website: www.susandrich.com under the icon for patient resources. The CAPSGW website also has a list of FASD community resources for patients compiled from the NOFAS website.

Report by CAPSGW Travel Grant Awardee, Kory Stotesbery, D.O.

Kory Stotesbery, D.O.

The 2012 AACAP Annual Meeting proved to be an experience that will have a lasting effect on my career. In nine months I will begin that career as I finish my Child and Adolescent Psychiatry fellowship. As a trainee the idea of moving out of the supportive environment of residency is extremely intimidating. The most daunting aspect, however, is the uncertainty of how to access the necessary professional support and guidance once in practice.

The field of psychiatry is in constant flux. On every frontier, we are continually advancing our understanding of the mind. While exciting, it also stands as a reminder that after training it will be essential to find a way to stay current. What will I do when the day comes when I don't have an attending down the hall to answer my questions or weekly didactics to update me?

Attending the Annual Meeting allowed me to understand that AACAP has a role in professional support throughout my career. This became evident to me as I attended a number of lectures discussing the role of technology and social media in patient care, where I had access to the researchers of this new frontier. I have had superficial education on this topic in the past. Suddenly, I felt like I had found a clear direction for my future practice.

The speakers examined social media and technology from all angles and offered clear recommendations with supporting data. Many speakers gave practical information: hours a day a child should access technology; the incidence of mental illness relative to time spent accessing technology; and strategies for parent education. However, I was most intrigued by a novel idea that we clinicians must embrace this technology ourselves. This idea was presented by Khalid Afzal, MD in a presentation entitled, The Emerging Role of Social Media Networks in Early Detection and Intervention of High Risk Behavior in Youth. Dr. Afzal's presentation differed from the previous speakers in that he embraced the role of social media in our patients' lives, rather than fearing the consequences of it. His study examined how frequently social media was used in connection with events that lead to admission to an inpatient psychiatric unit. He proposed the use of social media both as a screening tool for safety and as a portal for patient education on mental illness and safety. The meat of his point however lay between the numbers.

The easy answer to the emerging trend in youth's affinity for the online world is to restrict it but the better answer may be to understand it. Just like the emergence of television in the 20th Century, the Internet will play a potentially even bigger role in the lives of youth in the 21st Century. Our ability as clinicians to understand what our patients are doing and why could stand as the lynchpin in providing effective treatment.

This was further emphasized when I attended a poster session that focused on Massively Multiplayer Online Role Playing Games, or MMORPGs, (e.g. World of Warcraft). The data looked at the extent to which an acute, inpatient population used MMORPGs at home. The result: a lot. This exemplifies how many of our patients, particularly those with the most severe pathology, are drawn to virtual worlds. These children and teenagers are using such technological outlets to cope with their stress; in other words, MMORPGs, multiplayer first-person shooters (e.g. Call of Duty), and/or social media (e.g. Facebook, Twitter, etc.) are often the first line of coping for these youth.

It seems the message is clear: integrating technology is essential in modern psychiatry. My immediate thoughts are pretty straight-forward. I plan to ask parents about how many hours a day their child accesses technology. From there parse out how much of that time involves the use of large format virtual environments that allow them to engage other users. Hopefully that information will allow me to understand how large a role these activities play in my patient's life.

It seems the important next step is to understand what these virtual worlds mean for my patients. These motives will be just as important as understanding why my patient chooses their friends, their future career, their role models. The bottom line is that I cannot know my patients without asking them about this thing they spend dozens of hours week doing. Why is the virtual world so appealing? Who is the virtual you, your avatar? What about the real world makes this virtual environment so appealing? In the case of social media I hope to understand the difference in their experience of the real world and a faceless world separated by a computer screen.

As a child of the 1980's the appeal of technology is not completely foreign. I can remember the enjoyment of becoming Joe Montana and guiding the 49ers to numerous championships. If I could be the first kid to take down Mike Tyson immortality would be my reward. However our games weren't didn't have real people behind them. Our games did live in another world. That is where my knowledge gap lies. How to fill that gap I'm not yet sure.

This is where I hope to see the field of psychiatry further embrace technology. Practitioners need more education so we can more closely approach this phenomenon on par with our patients. For our patients, if social media and video games occupy the large majority of their free time, how can we use it to our advantage? This could take a number of forms: mobilizing Facebook and Twitter to spread information in hopes of demystifying mental illness, creating a means for users to activate help if someone posts information that is

Assembly Report cont.

(Continued from page 6)

$25,000 for support of research. AACAP's investment portfolio includes about 4 percent of investment in pharmaceutical companies. In addition, Dr. Joshi mentioned that the Physician Payment Sunshine Act was passed in 2010 to enhance transparency between drug makers, physicians and the public. Information regarding transparency at AACAP is available at the following link: http://www.aacap.org/cs/root/AACAP.Transparency.

Dr. Richard Pan, a pediatrician and a representative to the California State Assembly spoke to the Assembly about advocacy. Advocacy includes: 1) patient advocacy; 2) legislative/policy advocacy; and 3) community based advocacy. While at UC Davis, Dr. Pan developed an advocacy training program for pediatric residents. Three components of social change includes: 1) data; 2) strategy for social change; and 3) the political will to get it done. He discussed his story about how he was elected to the California State Assembly without any previous political experience.

Kristin Kroeger Ptakowski gave the legislative update. AACAP and members have been involved in assisting with state planning and implementation of the child welfare psychotropic medication monitoring, which is the result of the GAO report issued in December 2011. She updated the Assembly on stimulant mediation shortages. AACAP met with House and Senate offices around this issue as well as the FDA around this. A new GAO study is looking at the shortage of stimulant medications. Liz gave updates for state issues, including the expansion of psychologists practice to include prescribing practices.

New advocacy resources are available on the AACAP website include information on the state health insurance exchanges. The Toolkit includes general facts and updates about what is happening in Maryland, D.C. and Virginia. It is available at the following link: http://www.aacap.org/cs/root/legislative_action/health_care_reform. In addition, a state advocacy manual is available at the following link: http://www.aacap.org/cs/root/legislative_action/state_advocacy_toolkit.

Towards the end of the afternoon, **Michael Houston** gave an update from the AACAP Website Task Force. Finally, congratulations to **Rachel Ritvo** who accepted the Catcher In the Rye Award on behalf of The Psychotherapy Committee. ■

CAPSGW Travel Grantee Report cont.

(Continued from page 8)

concerning for safety, or even our own work to advocate for game makers to look away from mental illness for their story lines.

I already have and will continue to see numerous patients who hold the online world in the same regard as their favorite sports team, favorite musician, or even their best friend. Their virtual lives are an integral part of their identity. As their clinician, it is my responsibility to meet them on their level. What exactly that means I'm not sure. We are just starting to see studies, rating scales (e.g Problematic Video Game Use Scale) and practice guidelines emerge. This again highlights the value for me in attending the AACAP Annual Meeting. I know that when such information becomes available, I will find it at the Annual Meeting. The prospects of life after training become brighter as I realize the value of all the resources at the Annual Meeting. Be it workshops on any topic necessary, access to industry leaders on those topics, or a developed infrastructure of mentorship for Early Career Psychiatrists, the Annual Meeting will always have what I need to continue to develop as a psychiatrist.

I would like to thank both the CAPSGW Executive Committee for selecting me to receive the 2012 CAPSGW Travel Grant as the Membership for funding it. The Academy's dedication to supporting Early Career Psychiatrists has given me many opportunities for which I am already very thankful. I look forward to taking advantage of these as I begin my career and look for ways to pass on the same benefit to the next generation. Thank you. ■

CHILD AND ADOLESCENT PSYCHIATRIC SOCIETY OF GREATER WASHINGTON

Diane D. Berman
Executive Administrator
7621 Mary Cassatt Drive
Potomac, MD 20854
capsgw@verizon.com
Phone: 301-299-1393
Fax: 301-299-1393
www.capsgw.org

Follow us on Twitter! @ capsgw

Research Studies

Children's National Medical Center

Dr. Adelaide Robb and a team of psychiatrists and psychologists at Children's National Medical Center are conducting research studies with children and adolescents ages 6-17. Studies include treatments for depression, bipolar disorder, anxiety, schizophrenia and autism spectrum disorders. All study-related treatments and evaluation are FREE. Patient privacy and confidentiality is assured, and families may receive compensation for time and travel while participating. Please have patients contact Helen Burton or Lyndsey Keyte at (202) 476-6067. ■

NIMH

NIH Research Studies: Bipolar Disorder & Severe Irritability Symptoms: Enrolling Nationwide, Eligible Participants Ages 6-17.

Childhood Onset Psychotic Disorders: (Inpatient) Investigates the causes and treatment of childhood onset psychotic disorders. Eligibility Criteria: Medically healthy children ages 6-18 with an onset of psychosis by age 12.
Depression or Anxiety Disorders: (Outpatient) This study tests whether the drug fluoxetine may help treat major depression or anxiety disorders in children and adolescents. This is an 8-week study comparing the drug to cognitive-behavioral therapy or placebo. Eligibility Criteria: Medically healthy children ages 8-17 with major depression or anxiety disorders.

Social Anxiety & D-Cycloserine: (Outpatient) Examines whether an antibiotic, d-cycloserine (DCS), boosts the effectiveness of cognitive behavior therapy (CBT) for social anxiety. Eligibility Criteria: Medically healthy ages 7-55.

Attention Deficit/Hyperactivity Disorder (ADHD): (Outpatient) Through brain imaging, tries to learn more about how the brain works to control behavior in children who have ADHD. Eligibility Criteria: Medically healthy ages 8-17.

Attention Deficit/Hyperactivity Disorder (ADHD) and Brain Development: (Outpatient) Looks at the difference in brain development of children with ADHD whose symptoms improve over time versus children with ADHD whose symptoms persist. Eligibility criteria: Medically healthy, ages 4-8.

Autism: (Outpatient) This study will screen children and adolescents (and their parents) to determine the child's eligibility for participation in NIMH research studies on autism spectrum disorders, such as autism and Rett's Disorder. Eligibility Criteria: Medically healthy up to age 18.

Study of Toddlers with Language Delay (Outpatient): The NIMH is conducting research to study the behavior and brain functioning of toddlers (starting at 12 or 18 months of age) with language delays and typically developing toddlers.

Children with Down syndrome have a Story to Tell!: Researchers at the NIH are conducting a research study on brain development and learning in children and young adults with Down syndrome. Children and young adults may be eligible to participate if they are between 3 and 30 years old and have a confirmed chromosomal diagnosis of Down syndrome.

Bipolar Disorder: (Outpatient) Evaluates the development and course of childhood bipolar disorder. Eligibility Criteria: Children ages 6-17 with bipolar disorder; must currently be in treatment with a psychiatrist.

Disruptive Behavior in Children: (Outpatient) Seeks to understand the biology underlying serious disruptive behavior using brain imaging. Eligibility criteria: Medically healthy, ages 10-17, with serious behavior problems lacking remorse.

For more information, you may call 301-496-5645 or 1-800-411-1222 (TTY 1-866-411-1010) or visit http://patientinfo.nimh.nih.gov. ■